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Interprofessional Collaboration Between Occupational Therapists and Nurses in an Acute Care Setting: An Exploratory Study

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Interprofessional Collaboration Between Occupational Therapists and
Nurses in an Acute Care Setting: An Exploratory Study

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A Culminating Project Submitted in Partial Fulfillment of the Requirements for the
Degree Master of Science Occupational Therapy
School of Health and Natural Sciences
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San Rafael, California

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This project, written under the direction of the candidates' faculty advisor and approved by the chair of the Master's program, has been presented to and accepted by the faculty of the Occupational Therapy department in partial fulfillment of the requirements for the degree of Master of Science in Occupational Therapy. The content, project, and research methodologies presented in this manuscript represent the work of the candidates alone.

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Abstract

Background. Collaboration between occupational therapists and nurses is key to a positive prognosis for their patients. Currently, there is a gap in the research on professional relationships between occupational therapists and registered nurses in acute care settings.

Purpose. To examine interprofessional collaboration between registered nurses and occupational therapy in an acute care setting. **Methods.** A phenomenological, qualitative design with use of semi-structured interviews was used. Interviewees were four occupational therapists and four registered nurses who currently work in acute care settings in Northern California and were recruited through a snowball, convenience and purposive sampling. Themes and subthemes that emerged from the data answered the research questions. **Findings.** The key factors preventing collaboration were: Time constraints, role confusion and overlap, personality factors, and lack of occupational therapy advocacy. **Implications.** This study may guide the development of interprofessional education to improve the collaborative relationship between occupational therapists and nurses to ultimately improve quality of care.

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Introduction

Health care in the United States is a team effort that includes registered nurses, occupational therapists, physicians, speech language pathologists, physical therapists, and many others. In order for a team-based health care approach to be effective, all team members must understand one another's roles to maximize efficiency and team collaboration (D'Amour, Ferrada-Videla, San Martin-Rodriguez, & Beaulieu, 2005). This paper will discuss three main areas that have guided us to the specific sphere of interprofessional collaborative care between occupational therapists and nurses working in acute care settings. These include a description of interprofessional collaboration in health care including the benefits, challenges and factors associated with interprofessional collaboration; an overview of the current knowledge base on interprofessional collaboration between occupational therapists, registered nurses and other disciplines; a description of the professional roles of occupational therapists and registered nurses in the acute care setting, and a discussion of the gap in the current literature regarding the relationship between occupational therapists and nurses in the acute care setting, thus establishing a rationale for our study.

Interprofessional collaboration is necessary to ensure that health care teams are efficient and able to provide clients with the highest quality of care. Interprofessional collaboration and collaborative practice are defined as the process of coordination, collaboration, and joint decision making between the client and the health care team in all areas of treatment planning and execution, in order to reach a determined goal, regardless of the health care setting or type (Canadian Interprofessional Health Collaborative, 2010). All involved professionals, regardless of their specific discipline, work together with the client to maximize care and the ability to reach specific and determined treatment goals.

For positive collaboration to occur among professionals, interprofessional education must first occur. Interprofessional education enhances interdisciplinary communication and understanding, creates mutual respect, and enhances shared values (Bridges, Davidson, Odegard, Maki, & Tomkowiak, 2011). This education may take place in either a formal setting, such as an educational course discussing different domains in the health care industry, or in an informal setting, where members from different disciplines learn about one another's specific area of practice in order to collaborate on teams and reach the best outcomes in client health care (World Health Organization, 2010). Practitioners who have been educated in this manner understand and value the interventions and domains of practice of other disciplines. Not only do these professionals employ clinical reasoning in their own practice, but they are also aware of how each discipline relates to the continuum of client care overall (D'Amour et al., 2005). Knowledge of the domains and practice of differing fields allows for proper referrals to be made and sets the foundation for collaborative practice in health care.

Interprofessional collaboration is vital to the health care industry for many reasons. If professionals understand the roles and responsibilities of other members of the treatment team, more positive outcomes may result. These may include an increase in appropriate referrals, timely preparation for discharge, coordination and agreement on health services and discharge planning, a more comfortable work environment, sense of value and respect by team members, improved staff retention rates, and increased institutional supports. Negative aspects of care may also decrease due to improved interprofessional collaboration, such as duplications in medical testing, health care costs, length of stay within a health care facility, medical complications and errors, mortality rates, and tension on health care teams (Connolly, et al., 2010; Sandberg, 2010; WHO, 2010). These outcomes are why the Health Resources and Services and Services

Administration (HRSA) instituted a coordinating center for interprofessional collaboration and education in preparation for the Affordable Care Act. HRSA administrator Mary K. Wakefield, Ph.D., R.N., echoes similar findings when she states, “Health care delivered by well-functioning coordinated teams leads to better patient and family outcomes, more efficient health care services, and higher levels of satisfaction among health care providers” (U.S. Department of Health and Human Services, 2012).

Interprofessional collaboration is beneficial if all members contribute; yet there are challenges that can impede this process. Although many professionals strive to positively affect client care through collaboration, they often struggle with balancing autonomy, independence, and maintaining the interests of the specific discipline of the practitioner (D’Amour et al., 2008). The development of collaborative practice takes time and is expensive, and interprofessional education must first occur to ensure that all team members know each other’s roles, domains, and responsibilities. Educators must develop a specific curriculum if this education takes place in a formal setting (Lawson, 2004; Connolly, et al., 2010). Specific protocols and procedures need to be institutionally developed, a time and space must be allotted for team communication and collaboration, technological systems may need to be changed to share data across health care teams, and the development of infrastructure is needed to support interprofessional collaboration and conflict resolution (Lawson, 2004; WHO, 2010).

The benefits of long-term collaborative practice often outweigh the initial costs of development. Once the foundation and infrastructure have been built to support collaborative practice, other factors are also needed. The World Health Organization’s (WHO) Framework for Action on Interprofessional Education and Collaborative Practice (2010) outlines many key elements necessary for the promotion of interprofessional collaboration, some of which are an

acceptance of collaborative practice in the workplace culture, supportive management, and legislation that allows for interprofessional collaboration to occur. Other necessary factors stated in the WHO Framework are a working environment that allots necessary time for team meetings and collaboration, the development of workplace policies regarding professional equity and collaborative practice, and government legislation that supports interprofessional education and collaboration.

Current research on interdisciplinary collaboration demonstrates that not all of these factors are in place to promote collaborative practice in all health care facilities. Research points to a lack of time allotted for sufficient team collaboration as well as deficient interprofessional education that may lead to role confusion and a misunderstanding of the responsibilities of particular disciplines within the health care industry (Connolly et al., 2010). While implementing new practices and procedures is difficult, managing such challenges, negotiating with institutions, and developing consensus among professionals is necessary for active collaboration to occur in the health care setting (D'Amour et al., 2008).

Literature Review

Interprofessional Collaborative Relationships Between Disciplines

Interprofessional collaboration includes a professional's ability to communicate with and carry out treatment in a productive and mutually respectful manner with other professionals (WHO, 2010). This collaboration has been researched in a variety of disciplines including physicians, respiratory therapists, registered nurses, physical therapists and occupational therapists. Piquette, Reeves and LeBlanc (2009) investigated team interactions between nurses, physicians and respiratory therapists in intensive care units during acute medical crises. Through semi-structured interviews researchers found that events both during and surrounding the acute

crises were equally important. All the professionals reported a common goal of “jointly providing optimal care to each patient of the unit” (p. 276), yet a clash of expertise led to conflict and reduced quality of care for patients. Conflict arose for three reasons, including: a general clash of professional knowledge, a lack of respectful recognition of each profession, and personality differences among members. Some health care professionals expressed the need for a more hierarchical form of conflict resolution. Researchers found that availability and receptivity mutual respect in professional interactions, and to being flexible during crises were all factors that fostered interprofessional collaboration (Piquette et al., 2009). Piquette et al. (2009) found that professionals will collaboratively provide a higher quality of care for their clients if they have interprofessional relationships comprised of mutual respect and positive interactions.

Research studies of interprofessional collaboration between nurses and doctors, specifically junior doctors and general practitioners, found that the two professions held different attitudes towards teamwork (Nathanson et al., 2011; Hansson et al., 2010). Doctor participants were found to be generally satisfied with the status quo but the nurse participants perceived a lower level of collaborations than the doctors. Some nurse participants felt that due to a lack of collaboration mutual decision-making responsibilities were not being shared between the two professions (Nathanson et al., 2011). Nurse participants were found to have a more positive attitude towards teamwork than doctors (Hansson et al., 2010). The nurse participants were far less satisfied with the amount of collaboration that occurred when compared with the doctor participants (Nathanson et al., 2011). Hansson et al. (2010) also examined where attitudes towards collaboration participants of different genders and ages. Neither gender nor ages were found to have a significant impact attitude toward collaboration in either.

Atwal, McIntyre and Wiggett (2011) examined relationships between physiotherapists and occupational therapists. Semi-structured interviews and a case study of a client were used to collect data related to participants' perception of risk and professional practice in regards to discharge planning (Atwal et al., 2011). Participants' perceptions varied and researchers found that participants reported a variety of risk concerns when deciding whether to discharge a client. Participants of different professions have varying opinions about best practice. Based on the case study, some participants refused to discharge the client to go home, while others recommended discharging the client home (Atwal et al., 2011). A concern noted among participants was concern about litigation issues. The researchers found participants used teamwork as a way to manage and share risk in regards to making decisions about client's discharge plans. Participants reported that working in a team served as a support mechanism for discussing risk, which provided reassurance to health care professionals who were concerned about litigation issues that may arise if clients are improperly discharged (Atwal et al., 2011). In order to facilitate person-centred care, healthcare professionals need teamwork for reassurance to take risks (Atwal et al., 2011).

Several studies (Barnes & Turner, 2001; Kennedy & Steward, 2012) examined the collaborative relationship between occupational therapists and teachers. Teacher participants reported frustrations about not having formal collaborative meetings with occupational therapists (Barnes & Turner, 2001). However, teacher participants understood that the occupational therapist's high caseload made it difficult to schedule regular meetings (Barnes & Turner, 2001). Some teacher participants reported that informal collaborative interactions, such as talking in the hallway are important times for occupational therapists and teachers to collaborate together and for teachers to express their concerns about students (Barnes & Turner,

2001). Occupational therapist participants reported a desire to increase collaboration with teachers (Kennedy & Stewart, 2012). Effective collaboration was found to be dependent upon many factors, such as clarifying the role of occupational therapist in the classroom, improving inter-personal skills among the two professions, understanding teamwork, and having regular meetings with teachers (Kennedy & Stewart, 2012).

Occupational Therapy Roles in Acute Care Settings

The American Occupational Therapy Association describes occupational therapy services as “the therapeutic use of everyday life activities (occupations) with individuals or groups for the purpose of participation in roles, habits, and routines in home, school, workplace, community, and other settings” (American Occupational Therapy Association [AOTA], 2014, p. S1). Those who qualify for occupational therapy services may be at risk for or have “[...] an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction” (AOTA, 2014, p. S1).

In an acute care hospital setting, patients are typically medically unstable and require stabilization during acute episodes, as well as potentially life-saving emergency medical or surgical procedures. Patients will have differing prognoses, and occupational therapists have the responsibility for determining their rehabilitative potential (Munday, 2005; AOTA, 2012). Occupational therapists in this setting must contend with these factors as well as pursue three primary objectives: education, initiating the rehabilitation process, and consultation (Pendleton, 2013).

Education is directed at increasing patient understanding as well as caregiver or family understanding of the parameters of their condition. Occupational therapists, along with physical therapists, are responsible for educating patients and caregivers about safety precautions, and for

discussing any contraindications or movement constraints involved with their condition.

Education can also include patient self-care tasks or the proper use of adaptive equipment to enable patients to regain independence despite their current condition (Munday, 2005; Pendleton, 2013).

Occupational therapists often educate patients after surgical orthopedic procedures in proper protocols, including weight bearing status parameters, range of motion limitations, and postsurgical precautions during everyday activities. They will also provide training in self-care activities such as bathing and toileting that may require new methods of execution. These methods can include education on the use of adaptive or durable medical equipment and compensatory techniques where appropriate (AOTA, 2012). Occupational therapists will have to consider any present cognitive or perceptual deficits and use adaptive strategies to address these (AOTA, 2012; Munday, 2005). With discharge and assisted self-care or even independence as primary goals for many patients, occupational therapists also begin to teach specific techniques for functional mobility, including bathroom transfers, kitchen mobility, bed mobility, and safe care transfers (AOTA, 2012).

The second objective of occupational therapy treatment in acute care is starting the rehabilitation process for patients who are able to tolerate therapy. This involves assessing the patient's tolerance for therapy, monitoring pain levels, facilitating early mobilization, restoring function, preventing further decline, and coordinating care, transition, and discharge planning (AOTA, 2012; Bissett, 2012). Some specific restorative measures occupational therapists use are activities that promote neuromuscular re-education, remediation of upper-extremity weakness and abnormal muscle tone, trunk stabilization, and balance to improve bed mobility and maintain upright posture for improved self-care and participation in meaningful daily activities (AOTA,

2012). However, the acute care setting poses unique challenges for providing interventions due to constraints related to the patient's condition and the hospital environment. For example, the occupational therapist may want to work on toileting, but cannot replicate the same obstacles that would be found at the patient's home, and therefore has to use clinical reasoning to determine if the patient is ready for discharge, rather than being able to observe a successful performance in a natural environment (Pendleton, 2013).

During this initial rebuilding process, occupational therapists are working collaboratively with the healthcare team, patient, and patient's family/caregivers in order to direct client-centered therapy (AOTA, 2012; Pendleton, 2013). Keeping the client's condition in mind, they help patients to find solutions to begin managing self-care, work, household, or leisure activities despite any fatigue, pain, or dysfunction they may be experiencing. This can include ergonomic solutions like positioning strategies to reduce pressure on skin, joints, muscles, or wounds in order to increase comfort and mobility (Bisset, 2012). This also involves encouraging positive behaviors and engagement in meaningful activities, which can be used functionally to enhance abilities, improve function and psychosocial wellbeing, and promote independence (Munday, 2005). Occupational therapists may also need to fabricate custom-fitted or ready-made assistive devices, protective orthoses, and splints to aid certain conditions, and educate their patients and families on proper use (AOTA, 2012).

The third main objective of occupational therapists in acute care settings is to communicate and consult about the needs of the patient for discharge. Occupational therapists are members of a multidisciplinary team in charge of discharge planning, and need to communicate with other members of the team to determine the patient's status for discharge (AOTA, 2012; Bisset, 2012; Woodrow, 2010). An important feature of an occupational

therapist's contribution to the team is consulting about the client's occupational performance and environmental concerns and/or modifications in the home to ensure safety (Bisset, 2012; Pendleton, 2013). Another contribution is making recommendations for the patient's transition to the next level of care, which could be acute rehabilitation, a senior nursing facility, or an outpatient clinic. When the patient is deemed ready for discharge home, it is the occupational therapist's job to develop home programs and instruct patients, family members, and caregivers in how to use the programs in order to continue rehabilitation (AOTA, 2012).

Wilding and Whiteford (2008) conducted a study in Australia on language, identity, and representation among occupational therapists in acute care settings. Findings from this study indicated that occupational therapists experience role stress and even role confusion in this setting based their beliefs that other professionals may encroach on their domain of practice and their lack of ability to articulate what their domain of practice entails. Role stress was reported to contribute to perceptions of role ambiguity, role incompatibility, and role conflict in cases of encroachment. Researchers concluded that ambiguity, confusion, and lack of clarity on the part of occupational therapy professionals hinders their ability to spread awareness and appreciation of the profession among other professionals, insurance agencies, and patients, which interferes with occupational therapy's ability to flourish as a profession. Implications for occupational therapy include educating future and practicing therapists on the use of intentional, direct, specific language to describe occupational therapy so that "every client, relative, other health-care profession, administrator and all those people with whom we are daily in contact, [are] aware and truly understanding of the profession that is occupational therapy" (Wilding and Whiteford, 2008, p. 185).

Registered Nursing Roles in Acute Care Settings

The scope of practice for registered nurses' varies widely from state to state, which sometimes restricts nurses from providing a broad spectrum of care while acting within the law. Some states have very specific legislation, while others are more vague and open to interpretation, which means that the basis of registered nurses' scope of practice is often based more on legal decisions than on ability, training, or education (IOM, 2010). Broadly, the definition of nursing practice includes those functions that provide for the basic health care of individuals with acute or potential health or illness problems, and requires a significant amount of scientific knowledge and technical skill to provide (Board of Registered Nursing [BRN], 2011).

The roles of nurses can be broken down into three primary functions: independent functions, dependent functions, and interdependent functions. Independent functions include general patient care, testing, and observations. According to the Board of Registered Nursing, general patient care includes those services that ensure patient safety, protection, comfort, and hygiene (2011). Patient care can also include performing disease prevention and restoration measures, as well as delegation and supervision of patient care performed by subordinate health care workers. Testing can include withdrawal of blood or collection of other bodily fluids such as urine, skin tests, and various immunization tests. Observations that registered nurses might make independently include the signs and symptoms of patient illness, general behavior, physical condition, and reactions to treatment. Based on these observations, it is the nurse's responsibility to make appropriate referrals, follow procedure for reporting, or to initiate emergency procedures for patient safety/stabilization (BRN, 2011).

The dependent functions that fall under the nurse's scope of practice are those functions that require the referral or prescription by a licensed physician, dentist, podiatrist, clinical psychologist, or other clinical professional specialists. Examples of these functions include, but are not limited to, medication provisions, therapeutic agents or modalities necessary to implement a treatment, certain disease prevention procedures, or rehabilitative regimens (BRN, 2011).

According to the Board of Registered Nursing, interdependent functions are the actions registered nurses take when they observe signs and symptoms of illness, reactions to treatment, behaviors, or physical conditions that they deem to be abnormal (2011). Interdependent functions nurses are authorized to administer related to changes in treatment or standardized procedures are set by their medical facility. Though these actions overlap with the physician's scope of practice, standardized procedures are policies and protocols that are developed collaboratively and agreed upon by administrators and health professionals, including physicians and nurses (BRN, 2011; BRN, 2012).

Further skilled practices, inferred as components of some of the above responsibilities, include administration of medication using a variety of modalities, palliative care, venipuncture or intravenous therapy, administering tubal feeding, and invasive procedures such as inserting nasogastric tubes, inserting catheters, or tracheal suctioning (BRN, 2012). It is also the responsibility of the registered nurses to assess patients, and educate patients and their families about their condition, which includes health monitoring and post-discharge care (BRN, 2012).

Furåker (2008) presented a study on the views of nurses from Sweden of their role within the acute care setting. According to Furåker, nurses expressed frustration from not being able to define the essence of their work, or with not having a job description and specific role guidelines.

Descriptions of their role tasks within this setting gave an indication that some components of nurses job are unclear to them and that they experience an ambivalent professional status. The nurses interviewed “characterized themselves as ‘being a spider in the web,’ ‘being everything’ or ‘being easy to approach’” (Furåker, 2008, p.939).

These views point to a complex and autonomous job where nurses must simultaneously make themselves readily available, flexible to others’ schedules or timelines, and cooperative with others who may have differing views. As indicated by findings of this study, this often leads to nurses carrying out duties that they do not regard as professional, such as basic procedures that could be completed by healthcare paraprofessionals or medical assistants. Routinely completing tasks that did not appear to require professional training led some to feel less competent in their jobs than their education prepared them for, but others reported the opposite. Nurses whose jobs focused more on technical and administrative duties over basic nursing duties reported feeling more competent in their ability to define their professional roles within acute the care setting (Furåker, 2008).

Interprofessional Collaboration Between Nurses And Occupational Therapists

In a study by Atwal (2012) researchers examined the relationship between occupational therapists and nurses in the acute physical health care setting. The study aimed to understand the perceptions of discharge planning by interviewing occupational therapists and nurses (Atwal, 2012). Researchers found that role confusion and difference of priorities caused problems between the two professions, and that there is a need for occupational therapists and nurses to establish their respective roles (Atwal, 2012). One occupational therapist participant reported “communication” was a problem that affected collaboration with nurses (Atwal, 2012). A nurse participant reporting feeling like they had to “chase” and “badger” occupational therapists in

order to speak to them. Occupational therapist participants reported feeling resentment towards nurses for their behavior towards them (Atwal, 2012).

Several studies (Fortune & Fitzgerald, 2009; Smith & Mackenzie, 2011) have examined the relationship between occupational therapists and nurses in acute psychiatric settings through the use of interviews. Nurse participants who worked with occupational therapists had trouble defining occupational therapy (Smith & Mackenzie, 2011). One nurse participant reported the problem was because occupational therapists had trouble justifying their work (Fortune & Fitzgerald, 2009). Some nurse participants perceived that occupational therapists did not know where their professional boundary lies (Smith & Mackenzie, 2011).

Occupational therapist participants stated that the nursing staff did not value their work and devalued the therapeutic aspect of the group program they ran (Fortune & Fitzgerald, 2009). Occupational therapist participants also stated that they felt there was a lack of understanding and respect for them (Fortune & Fitzgerald, 2009). Nurse participants were reported to hold preconceived views and negative stereotypical perceptions of occupational therapists (Smith & Mackenzie, 2011).

Historically, the role of nurses in the inpatient psychiatric unit has been all encompassing, thus nurse participants expressed strong views that nursing territory was being challenged by the occupational therapists (Smith & Mackenzie, 2011). Nurse participants also reported that their experiences communicating with occupational therapists one-to-one had been lacking. Nurse participants described situations where collaboration was possible with occupational therapists, but they opted to work independently (Smith & Mackenzie, 2011). The nurse participants did not perceive occupational therapists as integral members of the team (Smith & Mackenzie, 2011).

Statement of Purpose

Patients in acute care settings are heavily reliant on care from registered nurses, occupational therapists, and other professionals who work collectively to promote a healthy recovery. Due to the heavily overlapping roles of occupational therapists and nurses, collaboration between these two disciplines is key to a positive prognosis for their patients. This interprofessional relationship has the ability to either promote or create barriers to such outcomes. Therefore, in order for team-based care to produce optimal results for clients recovering in acute care settings, it is crucial for occupational therapists and registered nurses to accurately understand one another's professional role of the other discipline. This understanding may encourage the development of mutual respect between disciplines and create an environment conducive to high quality of care for clients.

According to Smith & Mackenzie (2011), nurses lack an adequate understanding of occupational therapy, and occupational therapists often feel undervalued by nurses, leading to poor interprofessional relationships. Currently, there is limited research on professional relationships between occupational therapists and registered nurses in acute care settings. Therefore, the purpose of this study was to further examine the interprofessional collaboration between registered nurses and occupational therapy in an acute care setting. By collecting data from occupational therapists and registered nurses on their perception of the roles of their counterparts' professional responsibilities and values, we have gained insight into the general quality of their relationship. The results and conclusions drawn from this data can be used to provide interprofessional education between occupational therapists and registered nurses to improve their collaborative relationship, which should ultimately improve the quality of care for clients in acute care settings. Thus, the research questions were:

1. What are the perceived roles and values that occupational therapists and registered nurses have of each other in acute healthcare settings?
2. How do occupational therapists and registered nurses currently collaborate in acute healthcare settings?
3. What are the major supports and barriers to current interprofessional collaboration shared by and exclusive to occupational therapists and nurses in acute healthcare setting?
4. What do occupational therapists and registered nurses believe could be done both individually and through external intervention to improve interprofessional collaboration in acute healthcare settings?

Theoretical Framework

The Person-Environment-Occupation (PEO) frame of reference is an OT specific model, which examines the dynamic interactions that occur between an individual, the environment, and the occupation the individual is engaging in within that environment. The manner in which these three factors interact with one another determines the occupational performance of an individual. If the interactions of these components are out of balance, the individual's occupational performance will be sub-optimal. As such, PEO facilitates increased performance by guiding interventions in any of these three areas (Law, et al., 1996). As occupational therapists and nurses have particular roles while working together within the acute care setting, the PEO framework is an ideal framework for exploring the topic of interprofessional collaboration.

A person, in the PEO model, is defined not only as an individual, but also as all of the roles and experiences that the person brings with them into a situation. This framework assumes that individuals are motivated and constantly adapting to their environment. The personal component includes such factors as spirituality, self-concept, cognition, health, and personality

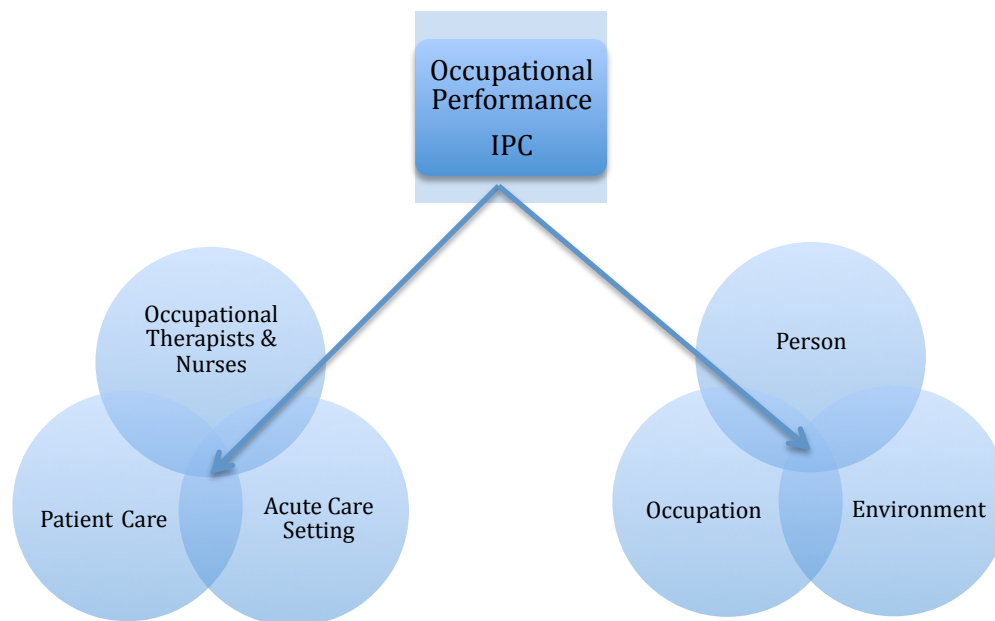
features (Law et al., 2006). Within the health care environment, both occupational therapists and nurses bring their skill sets, professional experiences, personal experiences, attitudes, and interests, which impact their interactions with clients and staff alike (Metzer & Metz, 2010).

The framework defines environment as situations and contexts external to an individual to which they must respond or react. PEO assumes that the environment is constantly in a state of flux, as it interacts on the person and the person interacts with it. The PEO framework also assumes that the environment is often easier to change than the person (Law, et al., 1996). The acute care environment discussed in this research topic includes factors such as the professions' activity demands, regulatory standards, hospital technology, as well as the working, cultural, and social environment (Law et al., 2006; Metzer & Metz, 2010).

In the PEO framework, the term occupation combines tasks, activities, and occupations. Occupation is the broader category under which the others fall. This framework assumes that occupations are complex, dynamic, and necessary for a person to feel fulfilled within his or her life (Law et al., 2006). The term occupation includes all actions and activities which are meaningful and purposeful to individuals throughout their lifespan, which can be completed alone or with others, and are influenced by culture, roles, and time of life (AOTA, 2014). For example, the occupation of being an occupational therapist or nurse includes specific activities such as writing goals and broader tasks such as discharge planning. Occupation in a healthcare setting also includes the components of clinical reasoning, continuing education, and mentorship (Metzer & Metz, 2010).

In the PEO model, these three components continuously interact and transact with one another, as is illustrated below in a Venn diagram. When the center overlap is large, then occupational performance is maximized. However, if the overlapping center section is small,

then occupational performance is minimized. If the area of occupational performance is small, PEO guides us to determine how to maximize the fit between the three interacting variables in order to increase occupational performance (Law, et al., 1996).



PEO examines these three components to determine occupational balance. As such, it is a useful frame of reference to understand interprofessional collaboration between nurses and occupational therapists. If the occupational performance of interprofessional collaboration between these two professions is minimal, then a change needs to occur. The domains of practice may not necessarily change, however the personal and environmental factors are dynamic and flexible. Perceived roles or personal biases may be altered, which may bring the realm of the person closer to the area of optimal occupational performance. The institutional, cultural, social, and physical environment may also be adapted to increase the opportunity for a

greater amount of interprofessional collaboration between these two professions (Metzer & Metz, 2010). By making changes such as these, occupational performance can be maximized in order to better facilitate the goal of interprofessional collaboration.

Methodology

Design

In this study we used a phenomenological, qualitative design to understand the experience of interdisciplinary collaboration from the perspectives of occupational therapists and nurses working in acute care medical settings. We conducted semi-structured interviews with four occupational therapists and four nurses who currently work in acute care settings. These interviews were audio recorded and transcribed verbatim. We focused on understanding the dynamic and complex factors in acute care settings that both drive and limit interdisciplinary collaboration, based on the participants' accounts of their experiences. We analyzed the data collected from the interviews and looked for themes about interprofessional collaboration between occupational therapists and nurses in acute care settings using a broad perspective. We gained insight into the perceptions held by each respective professional about the counterpart's role, how each valued the others' role, what they believed to be supports for and barriers to increasing interdisciplinary collaboration, and how they thought interdisciplinary collaboration can be improved.

Subjects

The participants were occupational therapists and nurses who currently work in acute care settings in Northern California. In acute care, patients are in critical condition and often require medical stabilization and life-saving procedures. The goal is to discharge patients as soon as they are physically able to handle rehabilitation. Though there are many departments within

acute care, occupational therapists and nurses are most likely to work collaboratively in orthopedic, neurological, and medical/surgical departments. Therefore, our research focused on interviewing occupational therapists and nurses from these departments within acute healthcare.

Inclusion criteria for this study was that participants were professional occupational therapists and registered nurses practicing in an acute healthcare setting for at least one year, and have had interprofessional experience co-treating patients. The years of experience and job location of participants were determined through our sampling procedure. Occupational therapists and nurses with jobs in any setting outside of acute care were excluded from the sample. There was no participant dropout. Participants were recruited from professionals in the field through snowball, convenience and purposive sampling where study participants were asked to help recruit more participants from among their occupational therapy or nursing acquaintances. We were able to attract an equal number of occupational therapists and nurses and benefitted from a balance of perspectives.

Data Collection Procedures

Each prospective participant was given a recruitment letter explaining the study's design, methodology, and possible risks involved. Those who agreed to volunteer received an informed consent document and Dominican University's Research Participant Bill of Rights (see Appendices A, B, and C). All participants met with one of the two designated interview researchers at a convenient location for a 20-30 minute semi-structured interview (see Appendix E). We created audio recordings, transcribed the recordings in full, and maintained detailed notes in order to capture details of the interview. The interview allowed for elaborative responses, which provided rich information on the collaborative relationship from each professional's perspective. The two researchers who did not conduct the interviews transcribed

the interviews to prevent interviewer bias during the transcription process. Researchers manually coded the transcripts, and collaboratively shared and discussed results.

Data Analysis

Data analysis was accomplished through interpreting participants' responses to answer the research questions. We also took detailed field notes, which included: initial impressions including visual observations of the environment and interviewee, nuances of the interview that could not be captured in the audio recording, reflexive feedback and insight following the interview, and process insight as we completed transcription and analysis. After transcription and reading of each interview was completed, we agreed upon distinct themes and sub-themes that emerged from the interviews. Within these themes, we compiled examples of responses and quotes that represented the theme. Those examples were then utilized in our discussion of that theme, and allowed us to answer the research questions.

Triangulating our data findings from different sources of information validated our theme choices. Following the theming and coding of the transcriptions, we discussed overlaps, similarities and differences in the responses between the occupational therapists and nurses. These comparisons allowed for interpretation about the phenomenon of interdisciplinary collaboration among occupational therapists and nurses within acute care. According to Portney and Watkins, "triangulation refers to a process whereby concepts are confirmed using more than one source of data, more than one data collection method, or more than one set of researchers" (2009).

Ethical and Legal Considerations

In order to maintain the trustworthiness and integrity of our research, and to comply with the research participant's bill of rights for ethical treatment, we adhered to the following legal

protocols and ethical guidelines. An application was submitted and approved by Dominican University of California's Institutional Review Board for evaluation and approval of this research study. Potential volunteers were asked to sign a consent form that allowed the researchers to make an audio recording of the interview. Participation in the interview was completely voluntary, and participants were able to decide to withdraw from the study at any point. All identities remained anonymous, except for the consent form, which was kept in a separate locked storage box than the locked storage box containing the audio recordings and encrypted USB thumb drive of the interview transcriptions. After one year all identifying documents will have been destroyed. Subject participation and/or their decision not to participate in no way affected participants' professional standing at work, or the reputation or status of the institution.

Our research also complied with standards set by the *Occupational Therapy Code of Ethics and Ethics Standards*, written by the American Occupational Therapy Association (AOTA). Certain ethical standards applied to our research more than others. The first was nonmaleficence, which dictates that our research intentionally excluded any actions that could cause harm to the participants. The second was autonomy and confidentiality, which dictates that we observed our participants' rights to self-determination and uphold our participants' confidentiality in our actions and reporting. The third was procedural justice, which dictates that we comply with all rules, regulations, and laws that applied to our research and our profession. This included, but was not limited to, our compliance to the rules of Dominican University's Institutional Review Board, the rules of each facility where we interviewed participants, the regulations set by AOTA documents, and local, state, national, and international laws governing the profession of occupational therapy. Finally, the fourth was veracity, which dictated that we

provide information that accurately, objectively, and comprehensively represents the truth in our communications, reporting, and in representing ourselves as occupational therapy students.

Results

As discussed previously in the data analysis portion of the methodology section, interview questions arose from our research questions. We chose to interview four occupational therapists and four nurses from different acute care facilities located in the California Bay Area. These eight semi-structured interviews were then transcribed and analyzed for patterns that emerged from the data. From these patterns, we determined five specific themes that greatly affect collaboration, four of which have specific subcategories. These themes are: Time, collaboration, communication, patient-centered care, and relationships. Table 1 details the demographics of the participants.

Table 1

Participant Demographics			
Profession	Years of Experience	Area of Acute Care*	Size of Facility
Occupational Therapy (all female participants)	<u>1-5 years</u> : 2	<u>Medical/Surgical</u> : 4	<u><50 Beds</u> : 0
	<u>6-10 years</u> : 0	<u>Orthopedic</u> : 3	<u>50-100 Beds</u> : 1
	<u>10+ years</u> : 2	<u>Neurological</u> : 3	<u>>100 Beds</u> : 3
		<u>Other</u> : 1	
Registered Nurse (all female participants)	<u>1-5 years</u> : 1	<u>Medical/Surgical</u> : 2	<u><50 Beds</u> : 0
	<u>6-10 years</u> : 2	<u>Orthopedic</u> : 2	<u>50-100 Beds</u> : 2
	<u>10+ years</u> : 1	<u>Neurological</u> : 0	<u>>100 Beds</u> : 2
		**Other : 3	

**Some participants reported working in multiple areas of acute care*
***Other areas reported include: Stroke, Cardiac monitoring, Chemo/Oncology, Vascular line and placement*

Time

Time was listed as the most significant barrier to interprofessional collaboration by seven of the eight participants in our study. The majority of the nurses stated that they are at times too busy to stop and talk with an occupational therapist about a patient's current state and that being asked to do so is frustrating. When asked about scheduling time to communicate about a patient or to enhance interprofessional collaboration, one nurse stated,

“When do you schedule the time?...[The hospitals] just add more-they always add more things for you to do. There's right now not enough time. So, you kind of always feel like okay, one more thing... so when something else comes up, it can be frustrating.”

However, nurses also recognized the importance of taking the time to discuss with other team members, as one long-term nurse said, “[Nurses] have all these things going on that are time oriented, so to actually break away from that tunnel vision and really work with the [therapists] in the other departments is very important for the patients.” Other nurses stated, “I don't have any time...so the really fast pace is causing it to be a big barrier to collaborate with anybody,” and, “We get so busy that we stop listening... and can't hear anything.”

Occupational therapists seem to understand the time restraints placed on nurses, however, it does take its toll on collaboration. One nurse even made a comment about it, stating, “There are certain times that often people are respectful enough to see it's not a good time to go approach that person they're very busy and it's not going to get me anywhere with the patient.” Occupational therapists comment on nurses' time limitations making statements such as, “They are much more rushed than we are. They are much busier,” and, “[Nurses] are so busy they don't want to be interrupted.” Time is definitely a barrier to interprofessional collaboration; however, nurses stated that she was grateful when the occupational therapist checked in with them prior to

seeing the patient. One even stated about receiving post therapy information, “It’s nice to get a short little update, but [nurses] don’t always have time.”

Collaboration

In order for professionals to collaborate as members of the health care team, it seems that it would be beneficial for the professions to understand the domain of each other’s discipline. Unfortunately, nurses and occupational therapists do not understand one another’s domains, or even roles, very thoroughly. The first half of Table 2 below illustrates the actual roles of nurses, and how these nurses perceive the roles of occupational therapists. The second half of Table 2 illustrates how occupational therapists define their role in the acute care setting, and how those occupational therapists define the role of nurses in the same setting. As you will see, at times the contrast is very poignant. Although all occupational therapists state that they work on ADLs, one nurse says that occupational therapists do not work on ADLs, and in fact, that the difference between physical therapists and occupational therapists is that the occupational therapists brings “gadgets” with them to patient sessions.

Table 2. Actual and perceived roles of nurses and occupational therapists

Actual roles/responsibilities of RNs	Perceived roles/responsibilities of OTs
<p>RN A: “I come in the morning and take my patient assignments...check the medication record...contact with my nurse assistant, some kind of game plan for the day, walking, bathing, those ADL type things.” “So it’s acute care so we obviously take care of, in my department, med surg...ortho and oncology. So we have chemo patients, cancer patients, and then electives, joint surgeries, falls, hips...general surgical patients is kind of our overflow.” “I’ll coordinate and make recommendations to the physician depending on the causation I have with the patient.”</p>	<p>RN A: “That has always been confusing for me with physical therapy...we have a couple occupational therapists that I’m seeing. The distinct difference that I notice is they’re bringing in tools for ADLs more than the [physical] therapist that’s just kind of mobilization, getting around. They’re using walkers, they’re using crutches that thing. Where the occupational therapist will come in and show them how to use the sock grabber or the you know the... all the little gadgets they have for that kind of thing.”</p> <p>In response to the interviewer’s question, “Do you see many occupational therapists doing</p>

	ADL activities, bathing and things?” The interviewee responded, “No... They may show the patient how to do it or have a brief discussion but it’s just not ultimately happening in the actual acute care setting... with the occupational therapist... the nurse and the nurses aids [do the personal hygiene].
RN B: “I do a variety of procedures. I work directly in patient care and teamwork with other members of my department [...] With the procedures there’s two rules for a nurse: we are assisting doctors with equipment and taking specimens things like that, or you do the other role which is sedation.”	RN B: “My understanding is that [OTs] come in to help assist patients that are having difficulty at home taking care of themselves doing their daily living type things such as feeding themselves and getting dressed and anything they would need to live on their own if that is possible without help.”
RN C: “I do patient care, so I coordinate a care plan, give medications, collaborate with physicians and coworkers and help people with personal care.” Read reports and charts, do physical assessments, and give medications.	RN C: “Assess the patient’s ability to do their basic ADL’s and to start working with them to improve whatever level they’re at and to improve that so they can do more things independently.” Assess ADL’s, improve function, and incorporate independence. “I believe they’re required by the facility to check with me and make sure it’s okay to start treatment.”
RN D: Medication dispenser, “cleaning people off,” helping with the bathroom, assess patients-look for changes, medicate, and treat to “move them to the next place”	RN D: Retrain how to get dressed and basic functions they will need when they get home, “maximize their ADLs,” early mobilization, brush teeth. Focused on the personal variable. “They really help us to get people to do things for themselves.”
Actual roles/responsibilities of OTs	Perceived roles/responsibilities of RNs
OT A says: “As an OT our focus is in ADLs...assisting patients, providing treatment that focuses on enabling the person to return to their state of line in things like bathing, dressing toileting and all of those skills, so our goal is based on where they were functioning prior to coming to the hospital...” “Typically before seeing a patient...we’ll	OT A says: “The role of nurses...they provide medication...they communicate with the doctor a lot and we communicate with them accordingly.” “I view the nurses as mostly primary care line to medication and managing pain.”

<p>check in with the nurses to ask...when was the patient last medicated, are they appropriate for treatment right now, what is their pain like..."</p>	
<p>OT B: "I do the evaluation and treatment of the patients that the doctor prescribes [...] and I look at physical therapy (notes) and speech notes and the three of us come up with a discharge plan with cross references." "A lot of family education, a lot of patient training, a lot of go-go-go right now in the hospital to get them out of the door quickly."</p>	<p>OT B:: "[Nurses] make sure I can work with the patient, that their vital signs are good, that their pain is good. [They] make sure that they have the patient pre-medicated and to do any dressing and changing if I'm going to be working with the patient. [They] unhook the IV and help me out by taking them out of their gowns..."</p>
<p>OT C: "Swallow evals., treatment, modified varying swallowing studies, and general occupational therapy." Assessment, treatment of ADL's and functional mobility." Chart review, coordinate with CNA's for ADL's, assessment, and start discharge planning immediately.</p>	<p>OT C: Manage cases, communication- act as a liaisons for everyone involved in the patient care (ie doctors, therapists, family, etc.), handles the direct needs of patients, medications, medical vitals, assist with self-care or independent care assistants. Positioning, infection control, report at rounds, and charting.</p>
<p>OT D says: Evaluate patients, determine prior and current level of function, set up goals, at evaluation determine discharge placement. Look at the functional side, ADLs, IADLs, functional mobility, strength/endurance. Check charts, look for orders, weight bearing status and precautions, check in with case managers and with nursing. Early mobilization. Functional transfers.</p>	<p>OT D says: Get patient medically stable, work alongside doctor, check blood pressure, vitals, hooking up IVS, medicating, pre-medicating before therapy, help coordinate discharge, work with case management. "Taking care of their medical needs is probably their primary goal."</p>

Role Confusion.

The domain of occupational therapy is frequently misunderstood. Enhancing that issue is that the role of occupational therapy also seems to change from facility to facility. It is possible that the occupational therapist is required by a site to check in with the nurse before going in to work with a patient, but it is also best practice to do so. In some settings, the nurses seem to

believe that the occupational therapists are there to shower people, especially before discharge.

One occupational therapist states that before a person is discharged:

“The [nurse] will call down and say, ‘I need an OT right now to shower this patient,’ ...we may be working with a patient...They don’t understand that we can be scheduled and that we’re not as flexible as they may need us to be, and that we should come right to them.”

There is much confusion from nurses about physical therapists and occupational therapists. Similar to the former statement about the confusion between occupational and physical therapists, an occupational therapist stated:

“[Nurses] call us physical therapists pretty often... I think they kind of see us come in and do the ADLs, the dressing, and bathing. Which is a huge part of what we do in acute care. But I think when they see us moving the patients they see more of PT. They don’t realize that we do functional transfers and mobility. We want to see them.”

A well-experienced nurse said:

“[OTs] don’t seem to have a big of focus on pain control or in need. Whereas the physical therapist for obvious reasons with mobilization a little bit more has to be there. So they’re more, ‘When was the last pain felt?’ that’s usually the question [PTs] ask the nurse.”

On the other hand, an occupational therapist stated:

“I check with [RNs] to make sure that I can work with the patient, that their vital signs are good. That their pain is good. I want to make sure that they have the patient premedicated and to do any dressing and changing if I’m going to be working with the patient.”

Another nurse commented:

“I think [we need to have] a better definition of what (sic) the occupational therapists are there in the first place. I think everyone kind of you know those blurred lines between therapists, we just don’t know how to use [OT] as a resource.”

Role Overlap.

There is obviously a role overlap between occupational therapists and physical therapists. One occupational therapist illuminating this overlap, stated, “There is a huge overlap with us and physical therapy. I just don’t think everybody realized that. It’s just kind of like how we see it and how physical therapy sees it.” However, an overlap between physical and occupational therapy is not the only overlap.

An overlap also exists between the roles of occupational therapists and nurses. Occupational therapists and nurses both work on ADLs, however the goals or purposes of working on ADLs are different between the two disciplines. As one occupational therapist said,

“[Nurses] definitely do ADL’s but they ‘do’ it. They don’t facilitate the patient doing it. So that’s an overlap for us...Our overlap with nursing would be the ADL’s for sure.”

The role of occupational therapy is to maximize independence for the patient. An OT may not work on a person’s ADLs if there is not a skilled need or if the person is too dependent.

For example, one occupational therapist stated:

“The nurses wanted us to do dependent... bathing and self-care even if they were max assisted/dependent...They had an expectation of us doing it even if there

wasn't a skilled component. So that created tremendous conflict with our departments for a long time."

Some role overlap allows for each discipline to reinforce the goals of the other discipline or to ensure that the therapy sessions will be successful. As one nurse said:

"I like to go to the bedside and see what [OTs are] teaching the patient because when they leave I can reinforce those things."

In order to ensure a successful therapy session, some degree of interprofessional collaboration is necessary. As one occupational therapist stated:

"I check with [RNs] to make sure that I can work with the patient, that their vital signs are good, that their pain is good. I want to make sure that they have the patient pre-medicated and to do any dressing and changing if I'm going to be working with the patient."

Communication

Communication was reported by interviewees as the primary means for collaboration between occupational therapists and nurses. Being able to communicate to one another is essential for optimal patient care. As one nurse stated, "The ultimate goal is we're all there for the patient. So I mean really, you're doing your patient justice to have [a] open line for communication." One occupational therapist stated, "I don't think that it is possible for us to work separately from each other. Sometimes with nursing or even therapists, sometimes people's attitudes can get in the way just like a lack of communication." Primary communication issues reported by interviewees included role advocacy and understanding of one another.

Role Advocacy

Results indicate that role advocacy is essential for occupational therapists to improve interprofessional collaboration with nurses. All four occupational therapist interviewed reported that role advocacy, specifically education, was essential to improving collaboration with nurses. One occupational therapist reported working with a nurse who interfered with treatment,

“Nurses are like, ‘Oh no don’t get them up just yet they still need to rest still,’ when mobilization is much more evident in helping patients progress and getting them back on their feet, strong again. So, education is both very important for therapists and nurses. Evidence-based is super important to help educate.”

The lack of knowledge of nurses about the occupational therapy profession and their clinical reasoning requires occupational therapists to advocate for their professional roles. One occupational therapist stated, “We educate them a lot on what our role is as occupational therapists... We are constantly educating nurses, CNA’s, and nursing staff... on our role in ADL management.” Another occupational therapist reported that education needed to be extended further than the nursing staff and stated, “There is definitely still a lot of education that needs to go on with the doctors as well, and even physical therapists for that matter, of what occupational therapists are doing.” Another occupational therapist reported how education has affected their collaboration with nurses stating,

“Education is the reason why I like to check in nurses so I get to know them. Like, ‘Hey, I’m an OT.’ I always introduce myself even though I already have previous times before... keep instilling it in their minds that this is what we do.”

These responses indicate that occupational therapists are consistently educating nursing staff and advocating for their professional role in the acute care setting.

Understanding the Other

Some nurses reported that there is little communication between the 2 professions and the nurses did not understand what occupational therapy is. A nurse stated, “I haven’t worked with occupational therapists before...but now we have an OT that comes around.” Although the nurse worked alongside occupational therapists the nurse did not perceive that collaboration was occurring at all. Later in the interview the same nurse stated, “They come by and just check in and say, ‘Is it okay for me to work with Mrs. Graveese,’” or whatever, and then I say yes and they go in...I don’t think I have been informed enough about what they really do.” Another nurse stated,

“I don’t think that I interacted enough with them... I’m kind of just starting to learn what to expect from them, how to ask them questions, and what questions to ask... We just don’t know how to use [occupational therapy] as a resource.”

This indicates that the lack of communication between occupational therapists and nurses are affecting their relationship with one another. When asked how the relationship between nurses and occupational therapists could be improved a occupational therapist stated, “Build their knowledge and education because it’s all about the patients and their needs... We just got to know more about each other.”

To improve communication and understanding between each other some occupational therapists praise the nursing staff and would write on patient’s board to help the nurses. One occupational therapist stated, “We write on the board to help the nurses: How much assistance do they need for transfers, what their specific needs are,” and another occupational therapist stated, “Just really validating [nurses] saying and making them feel important about what they do.” This indicates that occupational therapist are improving their collaborative efforts with nurses by

understanding their needs, while nurses are curious about occupational therapists do they are less likely to ask questions.

Patient-Centered Care

Patient-centered care is the standard of practice within healthcare, as it improves patient outcomes and has the potential to create better communication between coworkers. It was noted that a common theme amongst all interviewees is the purpose of their jobs centered on delivering patient-centered care. Both occupational therapists and nurses interviewed agreed that working together towards a common goal benefited their patients more than simply focusing on their own goals.

Common Goals

Irrespective of working as an occupational therapist or a nurse, several of the interviewees stated that delivering patient-centered care was their highest priority:

“Patient care. Absolutely. That’s number 1.”

“Working towards the patient’s goals is the priority.”

“The ultimate goal is we’re all there for the patient. So I mean really, you’re doing your patient justice to have kind of open...communication.”

One nurse commented that within the acute care setting where she worked, she noticed occupational therapists and nurses primarily work together towards the same goals and effectively reduce the number of challenges in patient care they would otherwise face:

“I think for the most part nurses and occupational therapists are striving to do the same thing for their patients and so they are always trying to work together as much as possible... Extra care settings require a lot more teamwork than other

places and if the staff is willing to and work really well together it could be a lot less challenging because the teams there are going to work together..."

Other nurses commented that when occupational therapists educate them about their treatment goals, they find it to be helpful in being able to carry on congruent and effective treatments on their own:

"I like to go to the bedside and see what they're teaching the patient because when they leave I can reinforce those things."

"They really help us to get people to do things for themselves."

"Most of the time they'll tell me things that they want me to work on with the patient, or things that they've seen, concerns that they have, things like that."

Occupational therapists also shared sentiments about how vital the assistance of nurses is while working with patients from the first day they arrive in acute care for reasons of safety, comfort, and medical expertise:

"[Nurses will] stay in the room with us, especially in the ICU to make sure that [the patients] are okay, especially if it's their first time getting up."

"I'm working with the nurses to make sure that [patients are] medicated... that their vital signs are good, that their pain is good."

"...We're doing all these [transfers] in conjunction with the nurse. So the two of us get the patient out of bed and into the chair [on] day one."

One occupational therapist interviewed took these sentiments a step further by stating that one could not do their job at all without the aide of the other:

“I really think it would be impossible for therapists to work without the nurses and vice versa in this setting because there is so much going on constantly... It is like a huge collaboration even just to get to the patient, to find out if they are even stable enough to be working with them... I think it is really important no matter what their diagnosis is to find out if they are medically even stable to be seen. They just may not be ready for mobility or maybe the doctor told the nurse something that we don't know yet.”

Conflicting Goals

Though the ideal work environment is one where people are collaborating, communicating goals, and sharing expertise through thoughtful education, interviews revealed that nurses and occupational therapists alike agreed this isn't always the reality. For a variety of reasons, occupational therapists and nurses frequently miss opportunities for communicating, advocating their role, and educating, and instead focus on their own goals. One nurse interviewed stated her belief that the whole system she was trained in could be to blame:

“The model of care and healthcare..is a barrier to my collaboration with any department.”

Another nurse agreed that nurses have been trained with a natural focus that does not always align with the perspectives or goals of occupational therapists:

“I think because nurses are so medically focused that we're more focused on the disease and I think OT's are a little more focused on the personal variable, to do for themselves; nurses get very 'nurse-y' and they want to nurse people.”

A third nurse put the situation of conflicting goals in perspective of the time everyone has allotted for their own goals, which can sometimes get crunched by the load and demand of working in acute care:

“[When nursing departments] get more and more stuff put on their plate... and everyone feels like their load’s really heavy...[nurses may react with the attitude of] ‘I’m sorry but I’m just doing the best I can do to do what I need to do,’ and sometimes, you know, there’s a priority and people may put therapy on the bottom of their priority in the nursing profession... In some places people are like, ‘I got to do my thing,’ and ‘I’m just going to do my thing,’ and it makes [collaborating] a lot harder.”

One occupational therapists interviewed stated her belief that nurses have the capacity to align their goals with those of rehabilitation, rather than simply focusing on medical model, but choose to distance themselves.

“[Some nurses] see the role of the rehabilitative care, but they are disconnected from it. I mean they don’t see that they’re a part of that. You know that they should carry through or follow up with any of it... Acute care, they are very medically-focused, so I think there is a disconnect.”

One outcropping of this disconnect can be seen by their understanding of the role of occupational therapy, as the same therapist stated:

“So [nurses] will call down and say, ‘I need an OT right now to shower this patient,’ we may be working with a patient... They don’t understand that we can be scheduled and that we’re not as flexible as they may need us to be, and that we should come right to them.”

Another occupational therapist agreed, stating:

“When the nurses see us come down on the floors, they go, ‘Oh, the OT’s here, the OTs are going to do that [bathing]’... I’m doing an assessment to see what I’m going to be doing, so I always say, ‘Hold on. I’m not sure. I haven’t read the chart yet, let me see what I’m actually doing with the patient’... They look at me like the bathing queen.”

Furthermore, another occupational therapist stated part of the problem created by nurses’ lack of understanding or education about the role of occupational therapy or the goal of therapy in general can be seen in therapists’ lack of utilizing nurses:

“More and more evidence is coming out that early mobilization is key and a lot of nurses are like, ‘oh no don’t get them up just yet they still need to rest’... Some nurses are not educated on the up and coming, you know, what’s best for the patient. So they might be hindering the patient more than they should be when they could be getting up and moving. So I know a lot of therapists might just go in and see the patient without going in and checking on the nurse because they just think they know what is better.”

Relationships

Interpersonal relationships are an association or acquaintance between two people ranging in depth and intensity. This connection and rapport built between occupational therapists and nurses has the potential to both improve and/or inhibit interprofessional communication and overall quality of care for acute care patients. Both positive and negative aspects of interpersonal relationships were discovered through the interview process, which are highlighted through direct quotes below.

Positive

Amongst the nurses and occupational therapists interviewed, there was a collective agreement on positive aspects of this interprofessional relationship and the importance of developing it. One occupational therapist said, “Trying to develop rapport right from the get go I think is really important...[and] personality plays a huge role... It’s just really important to develop a rapport with them.” One nurse stated, “We all have these conversations with the team that we could have a really hard day but, you know, we know we got each other’s back and that makes all the difference in the world.” Having a relationship, regardless of how deep it is, makes a difference in the collaborative dynamics of the acute care workplace. With this relationship comes a mutual respect for one another. One nurse said,

We have really good communication and really good... common respect for each other’s profession I think... It’s really good for them to have a... rapport or connection. So that’s really helpful and we have good teams in that regard so I think that is really an important part to... the setting.

Another nurse said, “There are certain times that often people are respectful enough to see it’s not a good time to go approach that person they’re very busy and it’s not going to get me anywhere with the patient.” One occupational therapist shared her perspective that, “The nurses are really good at asking and making sure that I’m in to see the person before they go home and get discharged.” As an outcome of this mutual respect a nurse stated, “...everyone is a lot happier because we talk to each other.” This personal acquaintance between professions was stated to incorporate an “...open communication...we have that kind of...rapport that relationship. That makes all the difference.” Teamwork is another component to positive relationships. One nurse stated, “Just keeping teamwork in mind, just really emphasizing it. Just working with

people in that space is important.” An occupational therapist agreed about teamwork stating, “Usually they’re happy to see us because it helps them. Its helpful to them to have us participate and take some of their load off.”

Negative

On the flip side, interpersonal relationships between nurses and occupational therapists in the acute care setting can have a negative component to them. A common theme that arose from both professions was the importance that personalities and attitudes play in developing a rapport with another person. One nurse stated, “...[some] have personality issues you know...[a] staff member that maybe isn’t as flexible or isn’t as willing and open to having a conversation.” The occupational therapists had more to say about nurse personalities and a disconnect they experienced with nurses in the workplace due to personality differences. One therapist said, “They just don’t want to be bothered, and some just have really strong personalities... Nursing staff has much more stronger personality traits than therapists because therapists are much more flexible...its such a stereotype.” Another therapist stated, “Sometimes people’s attitudes can get in the way just like a lack of communication... a lot of time people can have an attitude...[a] conflict of personalities a lot of times is a huge factor for therapists and nurses.”

Discussion and Limitations

Discussion

The interviews provided the researchers with numerous reasons leading to a lack in poor interprofessional collaboration between nurses and occupational therapists in an acute care setting. This study offers new insights into the effectiveness of interprofessional collaboration and the supportive contexts in which such collaboration can occur. A striking number of responses were similar between all of the professionals interviewed. Although there was often a

misunderstanding of roles between the disciplines, the factors working for and against collaboration were nearly unanimous. For example, time as a barrier, personality factors as a support or a barrier, and the need for occupational therapists to advocate for their profession and educate team members on the domain and role of the occupational therapist working in the acute care setting.

Lack of time was cited as a barrier to interprofessional collaboration by seven of the eight participants. As such, institutional supports need to be in place to ensure that sufficient time is allotted to allow for interprofessional collaboration to occur. This sentiment is echoed in list of supporting factors for interprofessional collaboration provided in the World Health Organization's (WHO) Framework for Action on Interprofessional Education and Collaborative Practice (2010).

Domain misunderstandings often led to frustration, lack of referral, or lack of use of occupational therapy as a resource. This role confusion illuminates a need for interprofessional education to increase interprofessional collaboration. Well-defined roles are important for all members of a health care team. The information provided by the participants during the interview process verify this statement made by the researchers Smith and Mackenzie (2011):

“Conversely, poor role definition within a team can cause role ambiguity, overlap of roles and confusion for clients, occupational therapists and other health professionals... Any uncertainty about the occupational therapy role in a health team will affect the consistency, frequency, and nature of referrals to occupational therapy by other health professionals” (p. 252).

The overlapping of roles between occupational therapists and nurses was mentioned numerous times by the participants, especially in the area of ADLs. However, nurses took more

of a bottom up approach and did the ADLs for the patient, whereas occupational therapists took a top down approach in attempt to maximize independence while assisting with ADLs. The different treatment models do impact the relationship and collaboration between the two professions. Researchers Fortune and Fitzgerald echo this in their discussion on the impact of occupational therapists not explaining to the treatment team the manner in which occupational therapists goals relate to function or how these goals “differ but complement others’ paradigms” (2009, p. 84). From the interview data, it is apparent that occupational therapists who explain to team members their goals, and their underlying clinical reasoning, may actually encourage others to reinforce the goal of increasing independence while participating in the areas where roles overlap, as in hygiene and self-care skills.

Communication was perceived to be a support and barrier to interprofessional collaboration by interviewee participants. Communication help builds rapport amongst occupational therapist and nurse to provide the best care possible for patients. In order to provide best care, it is essential for both professions to understand each other’s role. Nurses who were interviewed were unsure of the role of occupational therapists, and were unsure of how to utilize occupational therapy as a resource. In a study by Smith and Mackenzie (2011) nurses also reported feelings of uncertainty towards occupational therapy and how to utilize them.

To improve collaboration between the professions role advocacy was expressed by 4 occupational therapists interviewed to be an essential task to improve collaboration between the two professions. Occupational therapists reported education as being the primary means to fill in the gap of knowledge for nurses about the role of occupational therapy. Methods suggested by interviewees included giving presentations to explain occupational therapy profession and domain, building rapport with nurses by checking in with nurses before seeing the patient and

explaining to them what will be done with the client, and writing notes for nurses to read about what the assistance level is and what was done during the session.

All of the concerns in the sections here could be addressed through increased interprofessional education within the educational setting. Given opportunities for students from each discipline to work together in skills labs and practice labs would give the occupational therapy and nursing students a greater understanding of the respective roles and domains of each respective professions. Scheduling time for such interprofessional education at universities would decrease the problems that later occur in the workplace which stem from a lack of understanding.

Limitations

Asuncion, Rabello, Silangcruz, and VanDyk (2011) made the assertion that using a semi-structured interview format with open-ended questions has the potential to cause confusion on the part of the participant and the researcher. Also, participants may potentially be confused by the questions and have difficulty understanding how to answer them, which may cause difficulty in the researcher's understanding of the responses. For example, the questions, "What do you perceive to be barriers to collaborating with occupational therapists/nurses while working in acute care?" and "What do you believe nurses/occupational therapists could do to improve collaboration with occupational therapists/nurses in acute care?" were both difficult questions for the interviewees to understand and both required a number of prompts and examples in order for the meaning of the questions to be understood well enough for the participant to provide us with a clear answer. Another possible limitation to our study was the opportunity of the participants' to interact or collaborate with a nurse or occupational therapist. This limited opportunity was due to: varying degrees of experience, an environment lacking appropriate space for therapists

and nurses to communicate, or even the time of day that an individual works creating factors such as fatigue that inhibit communication. Such personal experiences, perspectives, and the ability to accurately recall information filter the information reported by the participants (Asuncion et. al., 2011).

According to Creswell, trustworthiness of phenomenological research is dependent on the accuracy of the information that is reported by interviewees, which can hinge on what the participants are willing to reveal (2009). Another limitation may have occurred from participants projecting their ideals of an interdisciplinary collaboration rather than sharing their true experiences. Inaccurate responses may be attributed to the presence of the interviewer, the fact that the interview is being recorded, or that they are in a different setting than their work environment. Inaccurate responses could also be a result of a participant's inability to accurately articulate and describe their true perspectives (Creswell, 2009).

Conclusion

Due to the gap in current literature examining the interprofessional collaboration between occupational therapists and nurses in an acute care setting, this exploratory research aimed to shed light on the collaboration of those disciplines within this setting. By gathering information on occupational therapists' and registered nurses' perceived roles of one another's respective professional responsibilities and values, we gained insight into the general quality of their relationship. This explorative study may in turn guide the development and implementation of interprofessional education between occupational therapists and registered nurses to improve their collaborative relationship, which will ultimately improve quality of care for clients in acute care settings. Due to the exploratory design of this research, our findings are based upon conversations with individuals and their personal stories and impressions. We suggest that further research is conducted using a mixed methods research design in order to establish generalizability of the data collected.

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Interview Recruitment Letter

November 13, 2013

Dear Study Participant,

My name is Bethany Loy, and I am a graduate student in the Masters of Science in Occupational Therapy program at Dominican University of California. I am conducting a research study as a part of my master's thesis requirements, and Dr. Eira I. Klich-Heartt, Professor of Nursing at Dominican University of California, is supervising this work. I am requesting your voluntary participation in my study, which concerns interprofessional collaboration between occupational therapists and nurses working in acute care.

Volunteering for this study involves participating in a semi-structured interview at or nearby your place of work, in which you will be asked questions about your experience with and knowledge of interdisciplinary collaboration between occupational therapists and nurses working in acute care. The interview will be approximately 30-40 minutes long and consists of six questions. You will be asked to sign a consent form that allows us to make an audio recording of the interview. However, participation in the interview is completely voluntary, and you may decide to withdraw from the study at any point. Your identity will remain anonymous, except for the consent form, which will be kept in a locked storage safe along with the audio recording of the interview. After one year all identifying documents will be destroyed.

Your participation or decision not to participate will in no way affect your professional standing at work, nor the reputation or status of the institution. The risk associated with participation in this interview would be potential negative impact on time (i.e. taking away from lunch break, adding to your after-work schedule, etc.), which could have potential financial risks associated with travel costs or otherwise. The potential benefits include contributing to a greater understanding of interdisciplinary collaboration between occupational therapists and nurses, potential improvements and beneficial changes in interdisciplinary collaboration in acute care settings.

If you have any questions, feel free to contact either Dr. Klich-Heartt or myself. My email is bethany.loy@students.dominican.edu. You may also contact my thesis supervisor by emailing her at eira.klich-heartt@dominican.edu or calling (707) 481-3115. You may also contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS). See attached Research Participant's Bill of Rights for contact information. If you would like to know the results of this study once it has been completed, a summary of the results will be presented at Dominican University of California's Academic Showcase in May 2015.

Thank you in advance for your participation.

Sincerely,
Bethany Loy

APPENDIX B

**IRBPHP
SIGNATURE PAGE (8.15)**

Select Type of Application: Initial Renewal Modification

Applicant Name: Bethany Loy

Project Title: An Exploratory Study: Interprofessional Collaboration Between Occupational Therapists and Nurses in an Acute Care Setting

Signatures:

I acknowledge that all procedures will meet relevant local, state, and federal regulations regarding use of human participants in research. I am familiar with and agree to adhere to the ethical principles in the conduct of research with human participants as set forth by the Dominican University of California IRBPHP Handbook.

[Redacted Signature]	12-4-2015
Signature of Applicant	Date
[Redacted Signature]	12/4/2013
Signature of Faculty Advisor*	Date

*Your signature indicates that you accept responsibility for the research described, including work by students under your supervision. It further attests that you are fully aware of all procedures to be followed, will monitor the research, and will notify the IRBPHP of any significant problems or changes.

***Category of Review:** Determined by faculty advisor or researcher.
(Note: See IRB Handbook pages 11-13 for category descriptions.)

- Exempt
 Expedited
 Full Board Review

For Renewal and Modification Applications only:
 Category of Review changed from Initial

[Redacted Signature]	12/10/13
Signature of Department Chair	Date

** Review by Dept Chair required for students in some disciplines.

Signature of Dean of School	Date

***Review by Dean is required for faculty researchers but not for student investigators unless this is a procedure of the School within which the student is majoring.

Please print and scan this signature page for your file and return electronically to june.caminiti@dominican.edu or in person to June Caminiti in Guzman 210.

**CONSENT FORM TO ACT AS A RESEARCH PARTICIPANT
DOMINICAN UNIVERSITY OF CALIFORNIA**

1. I understand that I am being asked to participate in a research study designed to assess certain personal attitudes toward interdisciplinary collaboration between occupational therapists and nurses in an acute care setting. This research is a for a master's thesis requirement for the Occupational Therapy department at Dominican University of California. This research project is being supervised by Dr. Eira I. Klich-Heartt, DNP, APRN, nursing department, Dominican University of California.
2. I understand that participation in this research will involve taking part in a 30 to 40 minute personal interview, which will include questions about professional experiences between occupational and nurses, barriers to interprofessional collaboration, and ideas on how to improve interprofessional collaboration.
3. I understand that my participation in this study is completely voluntary and I am free to withdraw my participation at any time without any adverse effects.
4. I have been made aware that the interviews will be recorded. All personal references and identifying information will be eliminated when these recordings are transcribed, and all subjects will be identified by numerical code only; the master list for these codes will be kept in a locked file, separate from the transcripts. Coded transcripts will be seen only by the researcher and the faculty advisors. One year after the completion of the research, all written and recorded materials will be destroyed.
5. I am aware that all study participants will be furnished with a written summary of the relevant findings and conclusions of this project. Such results will not be available until May 1, 2015.
6. I understand that I will be discussing topics of a personal nature and that I may refuse to answer any question that causes me distress or seems an invasion of my privacy. I may elect to stop the interview at any time.
7. The potential risks to my participation in this study include a loss of 40 minutes of my personal time and potential financial risks associated with travel time to and from the interview.
8. The potential benefits to my participation include contributing to a greater understanding of interdisciplinary collaboration between occupational therapists and

nurses, potential improvements and beneficial changes in interdisciplinary collaboration in acute care settings.

9. I understand that if I have any further questions about the study I can feel free to contact the thesis supervisor, a research student, or the Dominican University Institutional Review Board. I may contact the thesis supervisor by emailing her at eira.klich-heartt@dominican.edu or calling (707) 481-3115. I may contact Bethany Loy by emailing bethany.loy@students.dominican.edu. I may also contact the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with the protection of volunteers in research projects. I may reach the IRBPHS Office by calling (415) 482-3547 and leaving a voicemail message, by FAX at (415) 257-0165 or by writing to the IRBPHS, Office of the Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901.

10. All procedures related to this research project have been satisfactorily explained to me prior to my voluntary election to participate.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE EXPLANATION REGARDING THIS STUDY. I VOLUNTARILY GIVE MY CONSENT TO PARTICIPATE. A COPY OF THIS FORM HAS BEEN GIVEN TO ME FOR MY FUTURE REFERENCE.

Signature

Date

**RESEARCH PARTICIPANT BILL OF RIGHTS
DOMINICAN UNIVERSITY OF CALIFORNIA**

Every person who is asked to be in a research study has the following rights:

1. To be told what the study is trying to find out;
2. To be told what will happen in the study and whether any of the procedures, drugs or devices are different from what would be used in standard practice;
3. To be told about important risks, side effects or discomforts of the things that will happen to her/him;
4. To be told if s/he can expect any benefit from participating and, if so, what the benefits might be;
5. To be told what other choices s/he has and how they may be better or worse than being in the study;
6. To be allowed to ask any questions concerning the study both before agreeing to be involved and during the course of the study;
7. To be told what sort of medical treatment is available if any complications arise;
8. To refuse to participate at all before or after the study is stated without any adverse effects. If such a decision is made, it will not affect h/her rights to receive the care or privileges expected if s/he were not in the study.
9. To receive a copy of the signed and dated consent form;
10. To be free of pressure when considering whether s/he wishes to be in the study.

If you have questions about the research you may contact me at Bethany.loy@students.dominican.edu. If you have further questions you may contact my research supervisor, eira.klich-heartt@dominican.edu or calling (707) 481-3115, or the Dominican University of California Institutional Review Board for the Protection of Human Subjects (IRBPHS), which is concerned with protection of volunteers in research projects. You may reach the IRBPHS Office by calling (415) 482-3547 and leaving a voicemail message, or FAX at (415) 257-0165, or by writing to IRBPHS, Office of Associate Vice President for Academic Affairs, Dominican University of California, 50 Acacia Avenue, San Rafael, CA 94901

RESEARCH PARTICIPANT DEMOGRAPHICS

Code# RN ____ OT ____ M ____ F ____

Years of experience: 1-5 yrs. ____ 6-10 yrs. ____ >10yrs ____

Area of acute care: Med/Surg. ____ Ortho. ____ Neuro. ____ Other ____

Size of Facility: <50 beds ____ 50-100 beds ____ >100 beds ____

**INTERVIEW QUESTIONS
FOR BOTH OCCUPATIONAL THERAPISTS AND NURSES**

1) Tell me what your role is in the acute care setting at work.

Prompt: Tell me about a typical day at work for you.

2) What do you perceive to be the role of occupational therapists/nurses within acute care setting?

Prompt: Describe a time when you observed a occupational therapist/nurse working with a client and what you identified their professional role to be.

3) In what ways do you collaborate with occupational therapists/nurses?

Prompt: Give me an example of how you and a occupational therapist/nurse collaborated.

4) What do you consider to be supportive factors for collaborating with occupational therapists/nurses while working in acute care?

Prompt: Tell me in what ways do occupational therapists/nurses help to support the nurses/occupational therapists at work.

5) What do you perceive to be barriers to collaborating with occupational therapists/nurses while working in acute care?

Prompt: Describe to me a challenging time you have had with an occupational therapist/nurse while working together.

6) What do you believe nurses/occupational therapists could do to improve collaboration with occupational therapists/nurses in acute care?

Prompt: Give me some ideas you have about how nurses/occupational therapists can improve collaboration with occupational therapists/nurses.

7) What do you believe occupational therapists/nurses could do to improve collaboration with occupational therapists/nurses in acute care?

Prompt: Tell me what you think occupational therapists/nurses can do to improve teamwork with nurses/occupational therapists in acute care settings.